Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	DATE: September 17, 2007
Briarwood Nursing Center, Petitioner,	Civil Remedies CR1551 App. Div. Docket No. A-07-66
- v. -	Decision No. 2115
Centers for Medicare & Medicaid Services.	

FINAL DECISION ON REVIEW OF
ADMINISTRATIVE LAW JUDGE DECISION

Briarwood Nursing Center (Briarwood) timely requested review of the January 8, 2007 decision of Administrative Law Judge (ALJ) Richard J. Smith upholding the determination of the Centers for Medicare & Medicaid Services (CMS) to impose a civil money penalty (CMS) of $3,050 per day from September 11, 2002 through October 1, 2002. Briarwood Nursing Center, DAB CR1551 (2007) (ALJ Decision). Briarwood argues that the admitted errors in documenting monitoring of a resident known to wander did not cause or contribute to her elopement and death and should, therefore, not be the basis of a deficiency finding or an immediate jeopardy determination. Briarwood also argues that the additional deficiency findings upheld by the ALJ (all arising from the factual allegations surrounding the care and ultimate elopement of the same resident) should similarly be reversed because the resident's elopement through a window overnight was unforeseeable.

For the reasons explained below, we find that substantial evidence in the record as a whole supports the ALJ's factual findings about the resident's care and that Briarwood's legal arguments have no merit. Furthermore, Briarwood failed to show that the immediate jeopardy determination was clearly erroneous and did not show that it achieved substantial compliance prior to

October 1, 2002. Since the CMP imposed is the lowest amount possible for an immediate jeopardy determination, we must hold the amount reasonable. We therefore sustain the ALJ's decision to uphold CMS's imposition of the CMP totaling $64,050 for the period cited.

Background[1]

Briarwood is a skilled nursing facility located outside Atlanta, Georgia. ALJ Decision at 2; Briarwood Request for Review (RR) at 5. On September 11, 2002, Briarwood staff found a resident, called here R1, missing when they went to get her up for breakfast at 8:00 a.m. and began a search which went on for more than a week. ALJ Decision at 5 (and record citations therein). The resident was eventually found dead among kudzu vines behind a shed in a residential neighborhood. Id.; CMS Ex. 34, at 2; P. Ex. 35.

R1 was an 81-year old woman who was admitted to Briarwood in September 2001, a year before the tragic events at issue. ALJ Decision at 5 (and record citations therein). Prior to her admission, she had shown signs of dementia while living with and being cared for by a nephew in Florida. Id. After the nephew's death, she lived alone with nearby relatives looking in on her. Her dementia appeared to worsen, and she began to have wandering episodes. Id. In August 2001, she wandered away from the apartment they had shared and was found 24 hours later in an abandoned building. Id. She was kept in a psychiatric hospital unit for 10 days and placed on several psychotropic medications. Id.; CMS Ex. 11, at 1; P. Ex. 7, at 2. On release, she was transferred to Briarwood in Georgia where one of her nieces was employed as a licensed practical nurse. ALJ Decision at 5; CMS Ex. 11, at 1; P. Ex. 7, at 1.

No one saw R1 exit the facility but several factors suggested that she may have left by means of a window in her room. First, the facility used a Wanderguard system on its exit doors which would cause them to either lock or sound an alarm when approached by a resident wearing the corresponding bracelet. The doors were all checked and found secure and operational immediately after the resident's absence was noted. ALJ Decision at 5 (and record citations therein). R1 was still wearing her Wanderguard

[1] The following background information is drawn from the ALJ Decision and the record before the ALJ and summarized here for the convenience of the reader, but should not be treated as new findings.

bracelet when found. Tr. at 421. The bracelet continued to function properly when tested after her death. Id. Second, staff members reported that the window was open and the screen pushed out when R1 was found missing. Tr. at 520. Third, search dogs were able to pick up a trail using an article of R1's clothing beginning under the window and continuing to a nearby home and then along a sidewalk near a series of streetlights. Tr. at 546-49; P. Exs. 32-33. Unfortunately, the trail was lost before reaching the resident. Tr. at 549. Medical reports indicated that R1 likely died 24-36 hours before she was found. P. Ex. 34, at 9.

R1 wore a Wanderguard bracelet as one of the interventions in her care plan to address the facility's assessment that she was at high risk for wandering. P. Ex. 19, at 4. Among the other interventions which the facility planned were visual checks of R1 as needed but at least every two hours. P. Ex. 18, at 4; P. Ex. 33, at 1-2. The ALJ highlighted the following information from Briarwood records during R1's stay at Briarwood:

> Once admitted to the Facility, R1 continued to exhibit wandering behavior. During the week ending May 13, 2002, nursing notes state that R1 attempted to elope from the Facility and also she "question[ed] why is she in this facility in the first place." During the week ending July 21, 2002, nursing notes state that R1 again attempted to exit the Facility by walking out the front door. In a Resident Assessment Protocol dated August 26, 2002, the Facility noted that R1 "will wander due to her memory loss."

ALJ Decision at 5 (citations to record omitted). The window in R1's room was a sliding model with an exterior screen and was located at about hip-level just over an in-wall air conditioner. The window did not have any device to secure it against opening by the resident. The parties dispute whether such a mechanism would be appropriate in light of state fire laws. No alarm system was installed on the window.

Briarwood does not directly dispute any of these facts as found by the ALJ but rather disputes the legal significance of these facts. The question of the time at which R1 actually left the facility remains unsettled, and is discussed in the analysis section below.

Briarwood notified the state survey agency of the elopement the day it was discovered, as required. CMS Ex. 15, at 1. On September 26, 2002, a survey of Briarwood was completed and

resulted in findings that Briarwood was not in substantial compliance with various Medicare requirements, including 42 C.F.R. § 483.25(h)(2), which requires skilled nursing facilities to ensure that residents receive "adequate supervision" to prevent "accidents." The Statement of Deficiencies concluded that the conditions found at Briarwood presented an immediate jeopardy to the health and safety of its residents. Briarwood sought a hearing before the ALJ on all the deficiency findings and on the immediate jeopardy determination. Nov. 12, 2002 Request for Hearing. The ALJ held an in-person hearing and issued the decision that is at issue in this appeal. In that decision, the ALJ concluded, on the basis of circumstances surrounding R1's elopement, that Briarwood was not in substantial compliance with three Medicare requirements: 42 C.F.R. § 483.25(h)(2) (requiring "adequate supervision" to prevent accidents); 42 C.F.R. § 483.13(c)(1)(i) (requiring a facility to develop and implement written policies and procedures that prohibit . . . neglect"); and 42 C.F.R. § 483.20(k)(3)(i) (requiring that services provided by a facility meet "professional standards of quality").

Applicable law

Long-term care facilities participating in the Medicare and Medicaid programs are subject to the survey and enforcement procedures set out in 42 C.F.R. Part 488, subpart E, to determine if they are in substantial compliance with applicable program requirements which appear at 42 C.F.R. Part 483, subpart B. "Substantial compliance" means a level of compliance such that "any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301. "Noncompliance," in turn, is defined as "any deficiency that causes a facility to not be in substantial compliance." 42 C.F.R. § 488.301.

A long-term care facility found not to be in substantial compliance is subject to various enforcement remedies, including per instance or per day CMPs. 42 C.F.R. §§ 488.402(c), 488.408. CMS may impose CMPs ranging from $3,050 to $10,000 per day for one or more deficiencies constituting immediate jeopardy, and from $50 to $3,000 per day for deficiencies that do not constitute immediate jeopardy but that either cause actual harm or create the potential for more than minimal harm. 42 C.F.R. § 488.438(a). The regulations set out a number of factors that CMS considers in determining the amount of a CMP. 42 C.F.R. § 488.438(f).

"Immediate jeopardy" is defined as "a situation in which the

provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS's determination that a deficiency constitutes immediate jeopardy "must be upheld unless it is clearly erroneous." Woodstock Care Center, DAB No. 1726, at 9 (2000) (citing 42 C.F.R. § 498.60(c)(2)), aff'd, Woodstock Care Center v. Thompson, 363 F.3d 583 (6th Cir. 2003).

One of the participation requirements at issue here — that a facility ensure adequate supervision to prevent accidents — falls under the "quality of care" requirements, which share the same regulatory objective that "[e]ach resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care." 42 C.F.R. § 483.25. Section 483.25(h) provides in relevant part:

> *Accidents.* The facility must ensure that -
>
> * * *
>
> (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

The requirements of this regulation have been explained in numerous Board decisions. See, e.g., Liberty Commons Nursing and Rehab - Alamance, DAB No. 2070, at 3 (2007) (citing Golden Age Skilled Nursing & Rehabilitation Center, DAB No. 2026 (2006)); Woodstock, DAB No. 1726, at 28. Although section 483.25(h)(2) does not make a facility strictly liable for accidents that occur, it does require that the facility take all reasonable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigate foreseeable risks of harm from accidents. Woodstock, 363 F.3d at 590 (facility must take "all reasonable precautions against residents' accidents"). "Facilities have the 'flexibility to choose the methods of supervision' to prevent accidents so long as the methods chosen are adequate in light of the resident's needs and ability to protect himself or herself from a risk." Liberty Commons at 3 (citing Golden Age at 11 and Woodstock, 363 F.3d at 590).

Standard of Review

Our standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. Our standard of review on a

disputed finding of fact is whether the ALJ decision is supported by substantial evidence on the record as a whole. Guidelines -- Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs (Guidelines), ¶4(b), (at http://www.hhs.gov/dab/guidelines/prov.html; Batavia Nursing and Convalescent Inn, DAB No. 1911, at 7 (2004), aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson, 143 Fed.Appx. 664 (6th Cir. Aug. 3, 2005); Hillman Rehabilitation Center, DAB No. 1611, at 6 (1997), aff'd, Hillman Rehabilitation Ctr. v. U.S. Dep't of Health and Human Servs., No. 98-3789 (GEB) at 21-38 (D. N.J. May 13, 1999).

Analysis

Despite the lengthy briefing in this case, the matter can be resolved on a fairly straightforward basis. The deficiencies which the ALJ upheld all relate to the events surrounding the elopement and subsequent death of a single resident.[2] If we conclude, as we do for the reasons discussed below, that substantial evidence in the record supports the ALJ's findings and that, as a matter of law, it was not error for the ALJ to conclude that those facts established that Briarwood was not in substantial compliance with at least one of the cited regulatory standards, then that conclusion would suffice to uphold the ALJ Decision that CMS had a basis to impose remedies on Briarwood. Unless it was clear error to conclude that at least one deficiency thus proven created an immediate jeopardy, then the CMP amount must be considered reasonable since it is the lowest amount in the range of CMP amounts available in cases of immediate jeopardy.

Both parties take the position that the alleged noncompliance with section 483.25(h)(2) — which required Briarwood to provide R1 with "adequate supervision" to prevent her elopement – constitutes the core of the dispute, so we address that issue in some detail. Briarwood Br. at 25-26; CMS Br. at 41. We conclude below that the undisputed facts alone suffice to show that

[2] The ALJ noted that he was not directly addressing all of the deficiencies cited as a matter of judicial economy and because "substantial noncompliance with only one participation requirement can support the imposition of a penalty." ALJ Decision at 4, citing Beechwood Sanitarium, DAB No. 1824 (2004), aff'd, Beechwood v. Thompson, 494 F.Supp.2d 181 (W.D. N.Y. 2007). Thus, the ALJ discussed only three deficiency findings: 42 C.F.R. § 483.25(h)(2) (tag F-324); 42 C.F.R. § 483.13(c)(1)(i) (tag F-224); and 42 C.F.R. § 483.20(k)(3)(i) (tag F-281).

Briarwood failed to meet the standard in section 483.25(h)(2) because it did not comply with its own care plan for managing R1's well-known and well-documented wandering and elopement risk. We further agree with the ALJ that CMS's determination of immediate jeopardy was not clearly erroneous.

1. *The undisputed facts support the ALJ's finding that Briarwood failed to comply substantially with 45 C.F.R. § 483.25(h)(2).*

ALJ basis for finding noncompliance: The ALJ found that the care plan required staff to monitor her every two hours and Briarwood's staff admittedly did not do so during the relevant time. ALJ Decision at 8 and record citations therein. Close supervision was, as the facility itself recognized in its care planning, essential in light of R1's history of psychosis and dementia, her admission after a dangerous wandering episode, her regular wandering behavior – especially in the evening (sundowning), and her recurrent attempts to leave the facility. P. Ex. 18, at 2, 4; P. Ex. 19, at 4; Tr. at 66-67.

The undisputed evidence on the sequence of reported observations of R1 on the night in question may be summarized as follows:

- September 10, 2002 – 11:00 p.m. – Certified Nurse Aide (CNA) Smith-Warren reportedly noticed R1 going to her room, even though CNA Smith-Warren was not assigned to care for R1.

- September 10, 2002 – 11:30 p.m. - CNA Redding, who was assigned to R1, checked R1's room and observed that R1 was not present and that the bed was made. It was undisputed that CNA Redding did not take any steps to locate R1, did not report R1's absence to the charge nurse, did not document her observations, and did not check the sign-out log, although she testified that she thought R1 might have gone home with her niece. Briarwood later fired CNA Redding for failing to report a missing resident. CMS Ex. 19.

- September 11, 2002 – 2:00 a.m. – Charge Nurse Collins recorded in her midnight census that R1 was present. Nurse Collins later acknowledged that she did not actually see R1 but merely looked into the room and saw the curtain drawn around R1's bed. CMS Ex. 1, at 6. Briarwood later fired Nurse Collins for falsifying records to indicate that she visually checked on R1 when she had not done so.

- September 11, 2002 – between 4:15 or 4:30 a.m. – CNA Smith-Warren testified that on returning from a break she entered

> R1's room, for no particular reason, and exchanged a greeting with her. Tr. at 245.

ALJ Decision at 8. The ALJ noted that none of these observations were documented.[3] Id. The ALJ went on to conclude as follows:

> Even if R1 was seen at all the times stated above, as Petitioner contends, there is still a significant amount of time that passed between each sighting of R1. The Facility's policy is that each resident who is an elopement risk must be checked at least every two hours. P. Ex. 33, at 1-2; CMS Ex. 21, at 1-2. **Using the times that staff claimed to have observed R1 – 11:00 p.m., 2:00 a.m., 4:30 a.m. – and 8:00 a.m. when R1 was reported missing, there are gaps of three hours, two and one-half hours, and three and one-half hours, respectively. Also, the charge nurse falsified the midnight census report and counted R1 as present at 2:00 a.m. even though she had not actually seen R1.** CMS Ex. 19, at 2. The Facility's policy to check those who are elopement risks every two hours is adequate if followed; however, the Facility staff's inability to follow the policy shows that the Facility failed to ensure that each resident received adequate supervision.

ALJ Decision at 8 (footnote omitted; emphasis added).

The ALJ also emphasized his concern that Briarwood's failure to consider alternatives or take any action in relation to the risk of R1 using her window to leave the facility was problematic in itself. ALJ Decision at 6-8. It was undisputed that R1's window was neither alarmed nor secured against exit. The ALJ considered the window "an obvious escape route for a resident with such a

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[3] Of course, the charge nurse's census was "documented" in the sense that it was written down, but can hardly be considered reliable evidence of R1's whereabouts at 2:00 a.m., since the nurse never saw R1 and the record was admittedly falsified. In any case, the record fully supports the ALJ's evident doubt that R1's whereabouts during the night before her absence was discovered could be reliably established. Since the ALJ ultimately concluded, however, that, even were the evidence presented by Briarwood about "sightings" of R1 accepted, large gaps in supervision existed, it is not necessary to resolve conclusively the remaining questions about the reliability of those sightings. ALJ Decision at 9. What is certain is that the nurse aide whose assignment was to care for R1 that night never saw her and never checked on her whereabouts.

hazardous tendency." Id. at 6. The ALJ did not find persuasive Briarwood's claim that state law prohibited securing nursing home windows such that they cannot be opened because Briarwood cited no authority that would have restricted use of alarms on the window in R1's room.[4] Id. at 6-7.

Briarwood's arguments: Much of Briarwood's position on appeal is founded on its claims that the actions of its staff amounted to mere documentation errors that made no difference to the elopement and that its staff could not have foreseen that R1 would elope through the window. Thus, Briarwood insists that "we actually know that on the night she eloped, she was actually observed in her bed at about 4:30 A.M." Briarwood Reply Br. at 18. Briarwood also speculates that R1 left closer to 7:00 a.m.

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[4] Neither party included in its submissions citations to (or copies of) the state law or regulations on which Briarwood relied. Briarwood cites instead to its administrator's testimony as follows:

> Q. So to your knowledge – you heard descriptions yesterday of potentials of securing windows by painting them closed, or having them not be openable at all, be fixed, is that permissible in Georgia?
>
> A. In my knowledge, no.

Tr. at 420 (cited in Briarwood Reply Br. at 7, n.4). This testimony plainly fails to establish even that the administrator had a basis to believe that lesser measures than complete window closures were unavailable to her under Georgia fire codes. After R1's death, the administrator requested a waiver to permit her to secure the window screens to discourage window elopements and was told in writing by the fire marshal that no such waiver was required. CMS Ex. 36. The fire marshal's response casts doubt on the administrator as a reliable reporter of the requirements of state law in this area. Contrary to Briarwood's contentions, however, the ALJ did not entirely disregard the administrator's testimony but rather pointed out the limited scope of the restriction as she alluded to it. Compare Briarwood Reply Br. at 7, n.4 and ALJ Decision at 6-7. Briarwood has not shown that state law precluded all options to make windows less attractive as potential elopement routes, from securing screens, to limiting opening sizes, to alarm systems, and so on. Briarwood offers no evidence, in fact, that it considered any options but found them infeasible or made any effort to determine what would be permissible under the fire code prior to R1's death.

and concludes that nothing that happened prior to R1's departure could have been relevant in causing her death.[5] Briarwood Br. at 21.

Briarwood concedes that at least two actions by its nursing staff prior to that time (the failure to report R1's absence and untouched bed at 11:00 p.m. and the falsification of census records to show R1 present with no visual check) constituted violations of the facility's own policies significant enough to result in Briarwood terminating the employment of both persons involved. Briarwood Br. at 41. Briarwood states that it is not advocating a "no harm, no foul" standard, and that these two "nursing errors" might indeed constitute regulatory violations if they posed a potential for more than minimal harm.[6] Briarwood Reply Br. at 16, 18. Briarwood insists, however, that they cannot provide any "legal basis to impose liability for the Resident's demise" because they could have no causal relation to her elopement when the resident was "known" to still be safely in the facility as of five hours later. Id. at 17-18.

Discussion: At the center of Briarwood's position is its misapprehension of the concepts of causality and foreseeability in determining whether a facility has failed to comply substantially with section 483.25(h)(2). Briarwood's arguments suggest that, in order to show a violation of that regulation, CMS must show that an accident occurred, and that the accident occurred in a manner clearly presaged by previous actions of the particular resident and at an anticipated time and place, and that the accident was directly caused by actions of the staff

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[5] Briarwood's theory that R1 did not elope until shortly before she was sought for breakfast was based on its administrator's "feeling" that R1 must have had enough light not to slip on the gravel-covered slope. Briarwood Br. at 22 (citing Tr. at 427). Yet, Briarwood acknowledged that "no one knows for sure exactly when [R1] actually left the facility." Id. One of the dog handlers opined that R1 likely left during the hours of darkness because the route he tracked tended to follow street lamps. Tr. at 549, 569. Briarwood's attempt to reconcile these opinions by assuming R1 left just after sunrise but before the lights were turned off is not supported by any evidence in the record. Cf. Briarwood Br. at 22-23.

[6] In fact, counsel asserted at the hearing that "frankly we'll take a D, we'll take a potential for harm and be done with it." Tr. at 397.

that violated an explicit regulatory standard.[7] See, e.g., Briarwood Br. at 34. According to Briarwood, holding the facility responsible under any other scenario would constitute "strict liability."[8] Briarwood Br. at 27.

Longstanding Board jurisprudence has established the relevant elements of assessing whether a facility has failed to provide adequate supervision to prevent accidents. On the one hand, the Board has held that the "mere fact that an accident occurred does not, in itself, prove that the supervision or devices provided must have been inadequate to prevent it." Josephine Sunset Home, DAB No. 1908, at 13 (2004). On the other hand, it is not a prerequisite to finding noncompliance under section 483.25(h)(2) that any actual accident have occurred or be caused by the inadequate supervision in order to find noncompliance. Woodstock at 17. The occurrence of an accident is relevant to the extent the surrounding circumstances shed light on the nature of the supervision being provided and its adequacy for the resident's condition. St. Catherine's Care Center of Findlay, Inc., DAB No. 1964, at 12 (2005) (accident circumstances may support an inference that the facility's supervision of a resident was inadequate). The focus thus is on whether the facility took all reasonable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigate foreseeable risks of harm from accidents. Woodstock Care Center v. Thompson, 363 F.3d at 590 (facility must take "all reasonable precautions against residents' accidents").

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[7] Thus, as the ALJ noted, Briarwood contends that two-hour checks are not "mandated by the regulations or professional standards." ALJ Decision at 5 (citing Briarwood Post-Hearing Br. at 38-40). As the Board has repeatedly explained, the regulations do not focus on imposing checklists of specific measures every nursing facility must take but instead emphasize the results that facilities are to achieve while permitting a flexible choice of means. See, e.g., Golden Age. In any case, the relevant point is that, regardless of whether the two-hour checks were "mandated" by professional standards, Briarwood itself chose to set that standard in the plan of care it developed for R1.

[8] As counsel for Briarwood himself notes (Briarwood Br. at 27), and as the Board has repeatedly held, strict liability is not a relevant standard in these federal administrative adjudication, precisely because liability is a tort concept. See Guardian Health Care Center, DAB No. 1943 (2004). The issues before us go to regulatory compliance.

> The regulation speaks in terms of ensuring that what is "practicable" and "possible" to do is done. What is thus required of facilities is not prescience but reason and professional judgment in assessing what can be done to make residents (given their special needs) safe, through removing accident hazards, providing appropriate devices, and ensuring adequate supervision.

Josephine Sunset Home at 14-15.

In order to constitute a failure to comply substantially, the facility's acts or omission need only cause a potential for more than minimal harm. Even in the context of immediate jeopardy, CMS need only determine that serious harm was likely, not that it necessarily occurred. See Southridge Nursing and Rehabilitation Center, DAB No. 1778 (2001) (upholding immediate jeopardy determination despite the lack of serious actual harm and noting that it was merely "fortuitous" that such harm did not occur); Daughters of Miriam Center, DAB No. 2067 (2007) (upholding immediate jeopardy determination because CMS "had ample reason to conclude that DMC's noncompliance would likely have caused death or serious harm to Resident 4 in the very near future, but for her fortuitous refusal to accept the insulin injection, or to other residents had the facility not stopped the nurse from administering medications when it did").

We thus reject Briarwood's position that proof that the facility failed to monitor R1 in accordance with her care plan and/or failed to plan for the risks of her unsecured window, and thereby placed her at increased risk of elopement, is insufficient absent proof that this inadequacy of supervision directly led to her death. Furthermore, although Briarwood argues that two-hour visual checks would not necessarily have prevented the elopement, Briarwood's own administrator admitted that, had someone checked R1's room between 4:30 a.m. and 8:00 a.m., a search might have been started sooner. Tr. at 489. Obviously, since R1 was alive for at least some days after her elopement, the extra time might have meant greater chances of success in recovering her safely.

We also reject Briarwood's apparent position that an accident is unforeseeable simply because the facility reports not having previously known about or witnessed a similar accident.[9] We see

[9] Briarwood's actual position on the degree of foreknowledge of an accident risk required before it could be expected to take reasonable measures to protect its residents has

(continued...)

no basis for Briarwood's apparent theory that CMS must prove that a facility could have foreseen the precise manner in which an accident would ultimately occur before the facility can be held responsible for mitigating a risk. Josephine Sunset Home at 14 (rejecting the proposition that an accident cannot be considered foreseeable unless it previously "occurred to the same person in the precise manner," and further stating that "[f]or a risk to be foreseeable, it need not have been made obvious by having already materialized"). Instead, the Board has repeatedly explained that this regulatory requirement —

> obligates the facility to provide supervision and assistance devices designed to meet the resident's assessed needs and to mitigate foreseeable risks of harm from accidents. In addition, the Board has indicated that a facility must provide supervision and assistance devices that reduce known or foreseeable

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[9](...continued)
varied during the proceeding. On the one hand, Briarwood argues that R1's window elopement could not be foreseen because the facility staff was not "on notice that this Resident was at sufficient risk of the specific hazard of window elopement that the facility should have taken some specific action to protect her against it," especially since she was not shown to have tried to elope previously at 4:30 a.m. Briarwood Br. at 34. On the other hand, Briarwood concedes that "no one argues that a hazard is foreseeable only if, for example, a nursing facility's staff has actual prior experience with exactly the same hazard (such as the cases where a resident persistently elopes via a window)." Briarwood Reply Br. at 2. Briarwood contends, nevertheless, that at some point a hazard which actually caused an accident must be too "unexpected, remote or bizarre" to hold a facility responsible for failing to anticipate it. Id. Briarwood fails, however, to come close to establishing that the use of an unsecured, unalarmed and accessible window by an unmonitored resident with an identified high risk of elopement was so "unexpected, remote or bizarre" that no facility could be expected to take measures to minimize that risk. The Board has held that assessing foreseeability, simply requires looking at the "circumstances that were apparent or should have been apparent to the facility and then evaluat[ing] whether those circumstances – which can often be unique — were such that the facility could reasonably have anticipated the possibility of harm to the resident." Lutheran Home at Trinity Oaks, DAB No. 2111, at 17 (2007).

> accident risks to the highest practicable degree, consistent with accepted standards of nursing practice.

Century Care of Crystal Coast, DAB No. 2076, at 6-7 (2007) (citations omitted); see also Golden Age at 10-11.

Briarwood acknowledges in this case that it was aware that "some residents try to elope via windows" and that R1 was confused, had previously wandered unsafely, was prone to wander in the facility and sometimes packed her bags and announced her intention to leave. Briarwood Br. at 34. She had been assessed by the facility itself as high risk for elopement and the facility failed to implement its own care plan to minimize that risk, in addition to failing to consider the hazard presented by a window next to her bed. Staff at the facility insisted, even in the face of skepticism by the surveyor, that R1 was entirely capable of having left by that route. Briarwood Br. at 20 and n.11 (and record citations therein). Nevertheless, Briarwood points to no evidence that the staff had previously considered how to minimize that potential (or that any effort was made to determine what steps might be permissible under Georgia law such as the securing of the screens which proved not to even require a waiver). We conclude that substantial evidence in the record supports the ALJ's finding that it was not unforeseeable that R1 might elope through an unsecured window. ALJ Decision at 7.

Briarwood also argues that nurse aides are not required by regulation to chart every observation of or encounter with a patient. Briarwood Br. at 23, 43. This argument is a straw man. The problem here is not simply that the reported casual observations of R1 were not documented. The problem is that the nurse aide who was responsible for R1's care, which was to include visual monitoring checks as needed and at least every two hours, made no claim and kept no record of ever having performed such checks on the night in question. She simply never saw R1 and saw that her bed had not been disturbed and did nothing about it. She claims to have assumed that R1 had gone out of the facility on leave, yet she admits she never verified this assumption by reviewing the leave logs.

Briarwood attempts to substitute for the missing monitoring after-the-fact reports of other personnel who claim from memory that they noticed R1 at certain points during the night. The ALJ observed these witnesses and was in a position to determine what weight their reports deserved. He describes the equivocal nature of the "sightings" and explains that, even if they were all accepted, the facility policy was clearly violated. We see no

basis to place greater weight on these undocumented sightings than did the ALJ.

Plainly, this scenario was not a mere matter of having the two-hour schedule slip occasionally, since (1) all of the intervals substantially exceeded two hours; (2) none of the claimed sightings was documented or was made by someone intentionally visually monitoring R1; and (3) only two times did someone intentionally look for R1 to perform a visual check – first, her assigned aide who observed that she was not in her room and did not followup to find out where she was, and second, the charge nurse who admits to having falsified the single record of R1's presence during the night. Furthermore, as CMS points out, the nursing notes for R1 prior to September 10-11 show no record of any systematic monitoring as called for by the care plan. See CMS Ex. 33; P. Ex. 27.

We conclude that substantial evidence in the record as a whole supports the ALJ's finding that Briarwood did not provide adequate supervision to prevent accidents.[10]

2. *The ALJ committed no error in concluding that CMS's immediate jeopardy determination was not clearly erroneous and that the facility did not prove it achieved substantial compliance on an earlier date.*

As the ALJ correctly noted, under the applicable regulations, an immediate jeopardy determination must be upheld unless it is clearly erroneous. ALJ Decision at 14; 42 C.F.R. § 498.60(c)(2). Further, we agree with the ALJ that, unless the immediate jeopardy determination were found to be clearly erroneous, the $3,050 per-day CMP must be reasonable in amount as a matter of law since it is the minimum per-day CMP prescribed in the case of immediate jeopardy. ALJ Decision at 14. The ALJ found that, based on the evidence before him, CMS's immediate jeopardy determination was not clearly erroneous. Id.

Counsel for Briarwood argued at the hearing that the ALJ could not find immediate jeopardy unless a causal connection was proven

[10] Given that the parties centered their arguments on this deficiency finding and that the other findings upheld by the ALJ are largely derivative of the same facts, we are not discussing the other deficiency findings in depth. We have, however, thoroughly reviewed the arguments of the parties and the evidence in the record relating to each and find no basis to overturn the other deficiency findings.

between "the allegations and the result," that is to say, between the allegedly inadequate supervision and/or easily accessed window and the resident's death. Tr. at 397-98. We disagree. Immediate jeopardy is present under the regulations whenever the noncompliance "has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301 (emphasis added). Apart from reiterating its arguments that any failures by its staff could not have caused R1's death and that her elopement was unforeseeable (arguments we rejected above), Briarwood makes no argument that the immediate jeopardy determination was clearly erroneous. We therefore uphold the ALJ's conclusion that it was not clearly erroneous.

On appeal, Briarwood again raises the claim, rejected by the ALJ, that the CMP should have ceased to accrue at some date prior to October 2, 2002. Briarwood Br. at 48-49. Briarwood complains that the CMP began on a date "after all the events at issue occurred" and ended with no showing of any specific action "on or about October 2, 2002 that cured some persistent noncompliance on that date." Briarwood Br. at 49 (emphasis in original). Briarwood cites the statutory language empowering CMS to impose a CMP "for the days in which it finds that the facility was not in compliance" as restricting CMS to imposing a CMP only for those days for which it has made a finding of substantial noncompliance. Briarwood Br. at 48 and citations therein.

The Board has rejected the idea that CMS must establish a lack of substantial compliance during each day in which a remedy remains in effect. Lake Mary Health Care, DAB No. 2081, at 30 (2007). Such a rule would defeat the purpose of the CMP provisions to motivate prompt correction of problems and would be impractical as surveyors would have to constantly reenter and reassess the facility to determine its daily compliance status. The regulations require that, once a facility has been found not to be in substantial compliance, the facility must notify CMS of the date when it alleges that it has made corrections and come into substantial compliance, by means of a credible written allegation of compliance. 42 C.F.R. § 488.440(h)(1). The accrual of per diem penalties ends when the facility is found to have indeed achieved substantial compliance, usually through a revisit unless the deficiency is of a nature that correction can be verified through written evidence alone. Id. Here, the revisit survey on October 2, 2002 determined that substantial compliance was achieved on October 1, 2002. That was the date that Briarwood's plan of correction alleged that substantial compliance would be achieved so Briarwood can hardly complain about having been found in substantial compliance as of the first date on which it

alleged that it had made the corrections to achieve substantial compliance.

Despite Briarwood's insistence that the ALJ overlooked specific evidence proffered by Briarwood showing that it came into substantial compliance on some earlier date, we find no such evidence. Briarwood identifies various actions taken by the facility on intervening days, such as getting clearance for securing window screens on September 18 (actually the evidence indicates that the fire marshal explained that no clearance had even been needed), firing the two nurses on September 23, and upgrading the alarm system on an unspecified date. As the Board has explained –

> The burden is on the facility to show that it timely completed the implementation of that plan and in fact abated the jeopardy (to reduce the applicable CMP range) or achieved substantial compliance (to end the application of remedies). See, e.g., Spring Meadows Health Care Center, DAB No. 1966 (2005). It is not enough that some steps have been taken, but rather the facility must prove that the goal has been accomplished.

Lake Mary at 28.

Briarwood discounts the fact that its plan of correction was not submitted until October 1, 2002, claiming that nothing in the plan constituted "any significant change in policy or practice," despite its revisions of policies on documentation of resident checks and inservicing of the staff. Briarwood Br. at 49, n.26. The plan of correction constituted the facility's credible allegation of having achieved substantial compliance on October 1, 2002. Rather than having selected a random date as Briarwood implies, CMS found substantial compliance at the earliest date alleged by Briarwood. We find no error in the ALJ's conclusion upholding the duration of the CMP set by CMS.

Conclusion

For the reasons explained above, we affirm the ALJ Decision and uphold the imposition of the CMP described above.

Sheila Ann Hegy

Constance B. Tobias

Leslie A. Sussan
Presiding Board Member